

BCBSM PGIP PCMH Capabilities/Tasks

2009 Year 1 Initiatives

Patient Provider Partnership Initiative (CCP-08-02): Capabilities/Tasks

1.1	Practice unit has developed PCMH-related patient communication tools , has trained staff, and is prepared to implement patient-provider agreement or other documented patient communication process to establish patient-provider partnership
1.2	Process of reaching out to current patients is underway , and practice unit is using a systematic approach to inform patients about PCMH, including patients who do not visit the practice regularly
1.3	Patient-provider agreement or other documented patient communication process is implemented and documented for at least 10% of current patients
1.4	Patient-provider agreement or other documented patient communication process is implemented and documented for at least 30% of current patients
1.5	Patient-provider agreement or other documented patient communication process is implemented and documented for at least 50% of current patients
1.6	Patient-provider agreement or other documented patient communication process is implemented and documented for at least 60% of current patients
1.7	Patient-provider agreement or other documented patient communication process is implemented and documented for at least 80% of current patients
1.8	Patient-provider agreement or other documented patient communication process is implemented and documented for at least 90% of current patients

BCBSM PGIP PCMH Capabilities/Tasks 2009 Year 1 Initiatives

Patient Registry Initiative (CF-08-01): Capabilities/Tasks	
2.1	A paper or electronic all-payer registry is being used to manage all patients in the Practice Unit with diabetes
2.2	Registry incorporates patient clinical information, for all patients in the registry, for a substantial majority of health care services received at other sites
2.3	Registry incorporates evidence-based care guidelines
2.4	Registry information is available and in use by the Practice Unit team at the point of care
2.5	Registry contains information on attributed practitioner for all patients currently in the registry
2.6	Registry is being used to generate routine, systematic communication to patients regarding gaps in care
2.7	Registry is being used to flag gaps in care for all patients currently in the registry
2.8	Registry incorporates information on patient demographics and key clinical parameters for all patients currently in the registry
2.9	Registry is fully electronic
2.10	Registry is being used to manage all patients with asthma
2.11	Registry is being used to manage all patients with coronary artery disease (CAD) <i>[not applicable to peds practices]</i>
2.12	Registry is being used to manage all patients with congestive heart failure (CHF) <i>[not applicable to peds practices]</i>
2.13	Registry is being used to manage patients with any additional chronic condition for which there are evidence-based guidelines and the need for ongoing population and patient management , and which are sufficiently prevalent in the practice to warrant inclusion in the registry based on the judgment of the practice leaders
2.14	Registry incorporates preventive services guidelines and being used to ensure that all patients in the practice receive needed preventive services

BCBSM PGIP PCMH Capabilities/Tasks

2009 Year 1 Initiatives

Performance Reporting Initiative (IC-08-03): Capabilities/Tasks	
3.1	Performance reports that allow tracking and comparison of results at a specific point in time across the population of patients are generated for: Diabetes
3.2	Performance reports are generated at the PO, individual provider and clinic or Practice Unit level
3.3	Performance reports include all patients defined in 2.13
3.4	Data contained in performance reports has been fully validated and reconciled to ensure accuracy
3.5	Trend reports are generated, enabling physicians to track, compare and manage performance and patient results over time
3.6	Performance reports are generated for both adult and pediatric patients , if applicable
3.7	Performance reports include all patients defined in 2.14
3.8	Performance reports include all patient information defined in 2.2
3.9	Performance reports include information on services provided by specialists
3.10	Performance reports are generated for the population of patients with: Asthma
3.11	Performance reports are generated for the population of patients with: Coronary Artery Disease <i>[not applicable to peds practices]</i>
3.12	Performance reports are generated for the population of patients with: Congestive Heart Failure <i>[not applicable to peds practices]</i>

BCBSM PGIP PCMH Capabilities/Tasks

2009 Year 1 Initiatives

Individual Care Management Initiative (CCP-08-04): Capabilities/Tasks	
4.1	Practice Unit leaders and staff have been trained/educated and have comprehensive knowledge of the Patient Centered-Medical Home model, the Chronic Care model, and practice transformation concepts
4.2	Practice Unit is delivering coordinated care management services with an integrated team of multi-disciplinary providers and a systematic approach is in place to ensure care addresses patients' full range of health care needs
4.3	Systematic approach is in place to ensure that evidence-based care guidelines are established and in use at the point of care by all team members of the Practice Unit
4.4	At least one chronic condition has been identified for initial focus, and practice has assembled and is monitoring all key clinical data, clinical outcomes measures, process measures, and patient satisfaction/office efficiency measures
4.5	Action plan development and self-management goal-setting is systematically offered to all patients with the chronic condition selected for initial focus
4.6	A systematic approach is in place for appointment tracking, generation of reminders for all patients with the chronic condition selected for initial focus
4.7	A systematic approach is in place to ensure that follow-up for needed services is provided for all patients with the chronic condition selected for initial focus
4.8	Planned visits are offered to all patients with the chronic condition selected for initial focus
4.9	Group visit option is available for all patients with the chronic condition selected for initial focus, as appropriate for the patient
4.10	Medication review and management is provided at every visit for all patients with chronic conditions
4.11	Action plan development and self-management goal-setting is systematically offered to all patients with chronic conditions or other complex health care needs.

BCBSM PGIP PCMH Capabilities/Tasks 2009 Year 1 Initiatives

4.12	A systematic approach is in place for appointment tracking and generation of reminders for all patients
4.13	A systematic approach is in place to ensure follow-up for needed services for all patients
4.14	Planned visits are offered to all patients with chronic conditions
4.15	Group visit option is available to all patients with chronic conditions

BCBSM PGIP PCMH Capabilities/Tasks

2009 Year 1 Initiatives

Extended Access Initiative (CCP-08-03): Capabilities/Tasks	
5.1	Patients have 24-hour access to a clinical decision-maker by phone , and clinical decision-maker has a feedback loop within 24 hours or next business day to the patient's PCMH
5.2	24-hour patient access to clinical decision-maker (as defined in 5.1) is enhanced by enabling clinical decision-maker to access and update patient's EMR or registry info during the phone call
5.3	PCMH provider has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs during at least 8 after-hours per week
5.4	A systematic approach is in place to ensure that all patients are fully informed about after-hours care availability and location , at the PCMH site as well as other after-hours care sites, including urgent care facilities, if applicable
5.5	PCMH has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs (as defined under 5.3) during at least 12 after-hours per week
5.6	After-hours care provider is enhanced by enabling after-hours urgent care provider to access and update the patient's EMR or patient's registry record during the visit
5.7	Advanced access scheduling is in place reserving at least 30% of appointments for same-day appointment for routine and/or urgent care, or the majority of patients needing care are routinely seen on the same day
5.8	Advanced access scheduling is in place reserving at least 50% of appointments for same-day appointment for routine and/or urgent care, or all patients needing care are routinely seen on the same day
5.9	Practice unit has telephonic or other access to translator(s) for all languages common to practice's established patients.

BCBSM PGIP PCMH Capabilities/Tasks 2009 Year 1 Initiatives

Test Results Tracking & Follow-up Initiative (CCP-08-05): Capabilities/Tasks	
6.1	Practice has test tracking policy in place requiring tracking and follow-up for all tests and test results, with identified timeframes for notifying patients of results
6.2	Systematic approach and identified timeframes are in place for ensuring patients receive needed tests and practice obtains results
6.3	Process is in place for ensuring patient contact details are kept up to date
6.4	Mechanism is in place for patients to obtain information about normal tests
6.5	Systematic approach is used to inform patients about abnormal test results
6.6	Systematic approach is used to ensure that patients with abnormal results receive the recommended follow-up care within defined timeframes.
6.7	Systematic approach is used to document all test tracking steps in the patient's medical record
6.8	All physicians and office staff are trained to ensure adherence to the test-tracking policy; all training is documented either in personnel file or in training logs or records
6.9	Practice has automated test tracking system with Computerized Order Entry

BCBSM PGIP PCMH Capabilities/Tasks 2009 Year 1 Initiatives

E-Prescribing Initiative: Capabilities/Tasks

8.1	Practice Unit has capability to electronically print hard copy prescriptions, access at least some of patient's E-Rx history, drug allergy information, and clinical decision support information
8.2	Practice Unit has contract in place for licensed E-Rx program with capability to electronically transmit prescriptions point-to-point to pharmacy
8.3	Practice Unit has full E-Rx functionality, with full clinical decision support information, including formularies (i.e., RxHub/BCBSM-hub certified) and staff are fully trained in use of E-Rx